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2017 Annual Report, Auditor General:

Ministry of Health and Long-Term Care

Public Health Ontario

1st Session
42nd Parliament

Wednesday 24 October 2018

Chair: Catherine Fife
Clerk: Christopher Tyrell

Journal des débats (Hansard)

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Mercredi 24 octobre 2018

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 24 October 2018

Mercredi 24 octobre 2018

The committee met at 0901 in room 151.

COMMITTEE BUSINESS

The Chair (Ms. Catherine Fife): Good morning, everyone. I'd like to call the meeting of the Standing Committee on Public Accounts to order. The first item on our agenda is the motion moved at our last meeting by Mr. Miller. You all have copies of the motion in front of you and I will read it into the record.

Mr. Miller, Parry Sound–Muskoka, put into the record:

"I move that the Standing Committee on Public Accounts request that the Auditor General conduct an audit of the costs associated with illegal border crossers as it relates to all services provided through the government of Ontario and its municipalities for the three years ending July 31, 2018."

Further debate?

Mr. Norman Miller: We're ready to vote.

The Chair (Ms. Catherine Fife): I recognize MPP Lindo.

Ms. Laura Mae Lindo: I just wanted to make sure that we were really clear as to why we cannot support this motion. At issue is the language of "illegal border crossers." Really, I think the bigger issue is that this motion, I'm worried, will not provide the Auditor General with an opportunity to actually do the work at hand.

My understanding is that as members of public accounts, we're trying to find out whether or not the money being used in Ontario to support people who are seeking asylum in this particular instance is working—whether or not we're efficiently putting money into services that would allow folks to settle. The notion of where they cross doesn't seem to me to be where the issue is.

My question comes to what it is that we're asking the Auditor General to do. To be honest, the notion of "illegal border crossers" isn't legally sound. It's not included in any of the documents as the actual terminology that we would be using. You would say "asylum seekers."

I think what the government is trying to get to is the notion of unconventional crossing points, when they come in through means that were not the ones that we had determined where they should be entering. I'm not sure if I'm allowed to ask the Auditor General a question. Am I?

The Chair (Ms. Catherine Fife): You are.

Ms. Laura Mae Lindo: Okay. One of the questions I would have is, imagine somebody is seeking asylum—so they're coming in under pretty difficult circumstances—they get into Ontario and then they register at wherever they should be registering, so a place where everybody would agree is okay, and receive services. Would those people then be considered part of this audit on cost and return on investment etc.?

Ms. Bonnie Lysyk: The way that I see it worded now is for us to do an audit of the costs associated with people crossing the border other than at legal ports of entry. It would be up to the ministries and the municipalities that are asked to do this by the province to tabulate the costs associated with that. So they would basically identify the number of people who are crossing at non-legal ports of entry—crossing the border without going through the normal port of entry. They would identify the costs and the criteria that they use to identify those costs, and then we would attest to whether those costs are representative of the criteria that they gave us.

They're going to have to define for us what this means and tabulate the information, and then we will do a financial audit of the costs. We will not be able to do a value-for-money audit, but we'll definitely do a financial audit of the costs and estimates that have been prepared. But it will be up to the ministries and the municipalities to tabulate that and to give us something as a starting point.

Ms. Laura Mae Lindo: That leads me to another pretty major issue. In the Canada-Ontario Immigration Agreement, general provisions 2017, in the preamble, we speak to the foundational principles for the agreement that Ontario has with the federal government when it comes to immigration. Within that, it says that part of the foundational principles are the Canadian Multiculturalism Act, which is federal, which is fine, but also our Ontario Anti-Racism Act, which recognizes that "eliminating systemic racism and advancing racial equity supports the social, economic and cultural development of society as a whole, and everyone benefits when individuals and communities are no longer marginalized."

When I go to the act, in my capacity as the critic for citizenship and immigration as well as the critic for anti-racism, some pretty glaring issues come up—if we are in fact asking the ministry to do something that would be considered on all accounts racist, or perpetuating racism. I'm not sure how many people have read the Anti-Racism

Act of 2017, but when I flip through, it does discuss the need for Ontario to have an anti-racism strategy. "The government of Ontario shall maintain an anti-racism strategy that aims to eliminate systemic racism and advance racial equity." There will be no anti-racism strategy that would allow a bill with language like "illegal border-crossers" and a requirement for ministries in Ontario to use this divisive language as a starting point to see what's happening.

Ms. Bonnie Lysyk: I can give more context. The reason I didn't have a concern with the motion—how it's defined and how the information is compiled is for the ministries and the municipalities. We'll audit against whatever the criteria is they provide us. But when we did an audit—it was in chapter 3, "Settlement and Integration Services for Newcomers"—we did have a recommendation in there indicating that we'd recommend that the Ministry of Citizenship and Immigration collect relevant information to further inform its discussions with the federal government, which is responsible for immigration in Canada, with respect to the federal government's allocation of funding to the province. So when the motion was tabled the other day, it seemed aligned with what we had originally recommended.

In terms of the terminology, I think we were looking at it as persons who cross outside of legal ports of entry. But it will be up to you and the government to determine how you want this motion put to us to audit, and we will audit in accordance with that definition. We basically will look at schedules of costs and how that has been defined to see whether or not—I understand it is perhaps interpretable as being a federal-government-responsible cost versus provincial cost, and I think it's from the cost perspective that we would be looking at it.

Ms. Laura Mae Lindo: With it being from the cost perspective, there would be literally no—I understand and agree with what you're saying as the Auditor General. I don't think there's a problem with trying to find out costs, especially not with public accounts, and to know whether or not the money that's being spent is actually effectively helping people to settle in healthy ways; there is no problem with that. The issue is putting on record and into effect a motion that uses language that actually negates our Anti-Racism Act. It does the exact opposite of what another act, that does exist, that's the foundation of the agreement that we have, is telling us to do.

In my capacity as critic for citizenship and immigration, the use of language is hugely important. People are leaving their homes, and if they are, in fact, coming in through non-points of entry, or unconventional points of entry, then just say that. There's no reason to create a term that includes such divisive language and makes an assumption that what they're doing—seeking asylum—is, in fact, illegal. They may not have come through the port of entry that you would like them to come through, but that doesn't change the fact that they are here, and people deserving of support and respect.

In our last meeting, when we were last debating this, there was a shift and we were willing to talk about taking out the language of illegal border crossers, but through a confluence of things, we went back to the original motion. Again, being new, I don't know if I can put it back to the other members of the committee to ask whether or not we can now speak to amending the language and putting in, as the Auditor General has suggested, unconventional—how did you say it again, now? Because we had talked about various ways of doing it. I'm okay with "non-points of entry," "unconventional crossing points." But we can't ask the ministries to act in ways that perpetuate racist discourses. That would be counter to anything that I would be able to support.

The Chair (Ms. Catherine Fife): Are you proposing an amendment to this motion again?

Mr. Norman Miller: Excuse me, point of order: Would there not be a vote on the motion that's before—

The Chair (Ms. Catherine Fife): The motion that's on the floor right now can be amended, and this is what MPP Lindo is proposing. I'd welcome hearing from the government side if you're amenable to—once she moves the amendment, then you can debate that amendment.

Mr. Norman Miller: Is that correct, Clerk? Can it still be amended?

The Chair (Ms. Catherine Fife): Yes. That's what the Chair said and so that's what happens.

Do you have an amendment to the motion?

Ms. Laura Mae Lindo: The Auditor General had originally said other language, "non-points of entry."

The Chair (Ms. Catherine Fife): Do you want a five-minute recess to work this language out?

M^me^ France Gélinas: No, I think we've got it.

Ms. Laura Mae Lindo: I think we have it. How do you say it? "I would move that" the amendment be as follows?

M^me^ France Gélinas: Yes.

Ms. Laura Mae Lindo: I move that the Standing Committee on Public Accounts request that the Auditor General conduct an audit of the costs associated with asylum seekers entering non-points of entry as it relates to all services provided through the government of Ontario and its municipalities for the three years ending July 31, 2018.

The Chair (Ms. Catherine Fife): So you're proposing to replace "illegal border crossers" with "asylum seekers"—

M^me^ France Gélinas: Using non-—

Ms. Laura Mae Lindo: —"using non-points of entry."

The Chair (Ms. Catherine Fife): Non-conventional?

M^me^ France Gélinas: Non-conventional points of entry.

The Chair (Ms. Catherine Fife): Ms. Lindo, the Clerk has to make copies for everyone.

M^me^ France Gélinas: Can we ask for a friendly amendment?

Mr. Norman Miller: Point of order: When I did the initial motion, I had to give notice. Do they have to give notice for the amendment?

The Chair (Ms. Catherine Fife): No, members are allowed to amend a motion that's on the floor, Mr. Miller.

The Clerk will make copies, and we will reconvene in five minutes.

The committee recessed from 0914 to 0923.

The Chair (Ms. Catherine Fife): All members should have the amended motion before you. Ms. Lindo, do you want to read it into the record?

Ms. Laura Mae Lindo: Yes, and I just wanted to clarify that the new motion would be: I move that the Standing Committee on Public Accounts request that the Auditor General conduct an audit of the costs associated with people using non-conventional points of entry as it relates to all services provided through the government of Ontario and its municipalities for the three years ending July 31, 2018.

The Chair (Ms. Catherine Fife): Please explain to the committee how you've modified it.

Ms. Laura Mae Lindo: What was modified was that originally, prior to this, I had said—

Interjection.

Ms. Laura Mae Lindo: Oh, that part? We're just deleting "illegal border crossers" and substituting that with "people using non-conventional points of entry." There we go.

The Chair (Ms. Catherine Fife): Okay. Debate? Seeing no debate, I will call the question on the amendment to the motion. All those in favour of the motion? All those against—

M^me^ France Gélinas: Recorded vote.

The Chair (Ms. Catherine Fife): It's too late. You have to ask for a recorded vote before you vote.

That motion is lost.

So we have the original motion before us. Further debate? MPP Lindo.

Ms. Laura Mae Lindo: Where my concern is and why I cannot support this motion is that there is literally no reason to use language that would counter all of the work of our own Anti-Racism Act in order to do something that doesn't require that. You can use language like "non-conventional points of entry" to get to the exact same goal. You can say that you would like to find out how much money is going to people who are coming to Ontario through non-conventional points of entry, through—as language that we had agreed to at the last motion—persons who do not register themselves when they cross the border. We can use other language that will not perpetuate a myth about a group of people who are coming here to seek asylum and safety, and according to the 2017 Anti-Racism Act. If we actually want to do this work well, then we would have no argument with this.

There is absolutely nothing wrong with trying to find out the cost of having people come and settle in Ontario. There is nothing wrong with that. There is literally no reason to use language that would perpetuate racist myths about these people who are coming here, often fleeing violence and discrimination—all things that we say we would be open to having new folks come here to settle, and help in a healthy way. There is no reason to use the language.

So I put it back to the other members of the committee to explain why the need to use the words "illegal border crossers" is so important that you will hold up so much time and spend so much money to have this discussion over and over again. I don't understand why the words "illegal border crossers"—those words—are the be-all and end-all to achieve the aims that we have here. That's where my concern is.

The Chair (Ms. Catherine Fife): Thank you very much. Seeing no further debate, I will call the question—

M^me^ France Gélinas: Registered vote.

The Chair (Ms. Catherine Fife): You want a recorded vote? Registered or recorded?

M^me^ France Gélinas: Yes, recorded vote.

The Chair (Ms. Catherine Fife): Okay, there will be a recorded vote.

Ayes

Ghamari, McDonell, Norman Miller, Parsa, Surma, Wai.

Nays

Lindo, Morrison.

The Chair (Ms. Catherine Fife): I declare the motion carried.

It is close to 9:30. We will move into a closed session and receive the briefing from the Office of the Auditor General and the researcher. All members of the public must clear the room.

The committee continued in closed session at 0927 and resumed at 1231.

2017 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

PUBLIC HEALTH ONTARIO

Consideration of section 3.10, public health: chronic disease prevention.

The Chair (Ms. Catherine Fife): Welcome back, everyone. We are here this afternoon to consider public health: chronic disease prevention, section 3.10 of the 2017 Annual Report of the Office of the Auditor General of Ontario.

We have representatives from Public Health Ontario and the Ministry of Health and Long-Term Care here to answer the committee's questions. Thank you for being with us today.

I would invite you to introduce yourselves for Hansard before you begin speaking. You will have 20 minutes, collectively, for an opening presentation to the committee. We will then move into the question-and-answer portion of the meeting, where we will rotate back and forth between the government and opposition caucuses in 20-minute

intervals. I believe, this week, the government will begin their question set. You may begin when you are ready.

Ms. Helen Angus: I'll start off. My name is Helen Angus. I'm very happy to be here today. I'm the Deputy Minister of Health and Long-Term Care. I've been the deputy minister since June 29, 2018, so I wasn't the deputy when this audit was conducted, but I've done my best to study and understand the findings of the audit and the ministry's actions.

I'm joined here today by Dr. David Williams, on my right, who is the Chief Medical Officer of Health and the newly appointed lead for the population and public health division of the Ministry of Health and Long-Term Care. I'm also joined by Peter Donnelly, on my left, the president and CEO of Public Health Ontario. And in the first row we have Roselle Martino, who is the former assistant deputy minister of the population and public health division, who engaged with the Auditor General on this audit. So if there are some details required, I will ask Roselle to come up and join the table.

I want to start off by really thanking the Auditor General for this audit. We are very appreciative of the positive working relationship that we had with the Auditor General. I think that's evidenced by the greetings that you saw just a few moments ago. I want to give a shout-out to Sandy Chan, who led the audit team on behalf of the Auditor General. I think the audit is thoughtful and provides us with good guidance and good findings. You'll see from our responses that, really, we are entirely in agreement with the findings of the audit and are working towards making those findings true in terms of the delivery of public health services in the province. We certainly, as I say, welcome the recommendations and are doing active work on chronic disease.

I'm going to take a step back and just talk about why this is so important for the province, then we'll talk a little bit about the recommendations, and then I'll look forward to your questions.

Chronic disease: It's a complex issue facing Ontarians and health systems not only in Ontario but around the world. There are long-term conditions that develop slowly over time and often progress in severity. While they can often be controlled, they can rarely be cured. They include diseases that we're all familiar with: cancer, diabetes, respiratory diseases, heart disease, stroke and cardiovascular disease. They impair the everyday physical and mental functioning of individuals in the province and reduce their ability to do the activities of daily living that most of us enjoy. They're a growing challenge for us, as they shorten life expectancy and impact the quality of life, and they also pose increased cost to the health care system. Most of us living in Ontario will acquire at least one if not several chronic diseases over our lifetime. In fact, about half of people over the age of 12 in Ontario suffer from at least one chronic disease. So you can see that the disease burden is significant.

Unfortunately, the number of people living in Ontario with chronic disease is on the rise. We've got some stats here: In the period between 2003 and 2013, diabetes increased by 65%—some of that, obviously, relates to a growing and aging population, but it tells you that we've got diseases on the rise and we need to do something about them; high blood pressure, same time period, by 42%; and chronic obstructive pulmonary disease, which we call COPD, by 17%. So, really, chronic diseases are the leading cause of death in Ontario, accounting for approximately 79% of all deaths in the province. You can imagine, if we could actually prevent the onset or even delay the exacerbations of this, we could have an important impact both on the health of the population as well as on health care costs.

I would say that one of the other factors is that it's not evenly distributed across the province. Chronic diseases disproportionately affect some parts of the province and some communities more than others. A good example would be that the prevalence of diabetes, as probably everybody in this room knows, is three to five times higher amongst Indigenous communities compared to the general population.

It also, as I mentioned, places a significant burden on hospitals and other parts of the health care system, exacerbating some of the occupancy challenges and hallway health care that we are obviously seized with in other parts of my portfolio. In fact, I would say that major chronic diseases and injuries are estimated to account for 31% of direct, attributable health care costs in Ontario. Yet we go back to this: Most chronic diseases are either preventable, or onset can be delayed.

The good news in this area is that, in fact, there are really four common risk factors—and the Auditor General's report points this out to us—that can be mitigated to prevent chronic disease. If we align ourselves around those, we can actually make a dent in that. The first is smoking, the second is physical inactivity, the third is unhealthy eating, and the fourth is excessive alcohol consumption.

These four risk factors combined contributed almost $90 billion to health care costs in Ontario between 2004 and 2013. When we look at a study from the Institute for Clinical Evaluative Sciences, it suggests that 22% of the province's overall health care spending is attributable to those four risk factors that I just talked about. An additional study going back to 2012 suggested that the key risk factors for chronic conditions reduce life expectancy by about seven and a half years and that exposure to these risk factors is almost universal across Ontario, with virtually all Ontarians exposed to at least one risk factor in their lifetime.

Again, while this sounds dire, I think addressing the risk factors for chronic disease does and can have an impact over the medium to long term. My colleagues here who are public health practitioners will talk a little about things like lag effect and latency effect and when the benefits can accrue from changes in behaviour. In fact, healthy eating, regular exercise and not smoking can actually prevent up to 80% of type 2 diabetes and premature heart disease as well as about 40% of all cancers.

The challenge is that mitigating the impact of these risk factors is not immediate. What we talk about is that there's a latency effect in preventative programs that results in improvements not being evident for long periods of time. I think my colleagues will tell you about how long it takes for the benefits to accrue in cardiovascular disease versus cancer because they are different. This makes it a challenge for us to sometimes measure the effectiveness of some of our programs when we really want to look at those penultimate outcomes, which are really about survival and quality of life amongst the population.

I think, over the last 10 to 15 years, the previous government took steps towards chronic disease prevention and made some progress in addressing chronic disease risk factors. The good news around smoking rates in Ontario is that they dropped from 22.3% in 2003 to 17.4% in 2014. We also have a statistically significant drop in overweight and obesity in children in Ontario aged five to 11, from 39.5% being either overweight or obese to 25.6% in 2015. So we're on the right trajectory as it relates to some of those metrics.

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By reducing Ontario's unhealthy behaviours related to these common and modifiable risk factors for chronic disease, we estimated, again between 2004 and 2013, that the province saved about $4.9 billion. So there is a return on investment that I think is worthy of consideration.

If we go through some of the risk factors and what has been done to date—and again, the Auditor General's report does point this out—the government spent quite a bit of time focusing on smoking as a risk factor. I think you're pretty familiar with the work on the Smoke-Free Ontario Act and the measures underneath that to protect Ontarians from the harmful effect of tobacco use. It also helps people quit smoking and makes sure that young people don't get addicted to tobacco in the first place. We call that the SFOA back at the office. The Smoke-Free Ontario Act responds to the changing landscape in tobacco, but it has also become the foundation for how we're dealing with vapour products and cannabis. Through that vehicle, the current government has strengthened smoking and vaping laws by protecting people from second-hand smoke and vapour, regardless of whether it's from tobacco, electronic cigarettes or cannabis, and trying to keep harmful products out of the hands of children and youth.

In the area of alcohol, the previous government also implemented initiatives that support responsible consumption of alcohol and prevent alcohol addictions. I would point to the low-risk drinking guidelines, which really promote a culture of moderation. I would say that the current government is on its way to developing and implementing a comprehensive mental health and addictions strategy in Ontario to support those struggling with alcohol addictions and giving them the help that they need. It is, according to the government's platform, a 10-year plan. We're in the early stages of making sure that the investments we make in that are actually going to achieve real results for the people of Ontario.

Finally, the ministry has done interesting work in the areas of unhealthy eating and physical activity through the province. I would point to things like free, evidence-based nutrition and healthy eating information through the registered dietitians and through Telehealth Ontario. That's in order to help inform healthier food choices. Menu-labelling legislation: Again, some of us have taken advantage of that so that when we go to any restaurant that has more than 20 outlets, we can actually see the calorie counts on menus. I hope that I've personally taken advantage of that and made healthier choices, but it does give consumers the kind of information that they need to be able to do that. We also have 24/7 access to nurses and lactation consultants to provide breastfeeding advice and referrals.

There are fruit and vegetable programs for school-aged children in northern communities, and we have healthy eating and active living programs in Indigenous communities as well. They began under the direction of the previous government and have been maintained in the 2018-19 fiscal year.

We're going to evaluate these as we evaluate all programs, doing our line-by-line review to make sure that government resources are applied in ways that are efficient and effective to address the chronic disease risk factors. I would point out that that kind of approach to reviewing the programs is entirely consistent with the value-for-money audit done by the Auditor General.

I think it's also important to talk about chronic disease prevention and the number of partners that are involved. Clearly, public health is probably one of the most important players in the prevention of chronic disease, but there is a whole lot of other organizations and providers who actually have an impact on the behaviour of individuals and how we either embrace, or not, behaviour modification and the understanding of risk factors. That would include local government, community organizations and front-line health care service providers. They really all work together. I would probably do a special call-out to—many of us would probably have advice from our primary health care provider about weight and other things. They're an important part of the arsenal in dealing with chronic disease.

It takes place almost everywhere in the health care system. For example, as I say, providers in primary care settings, whether that's nurse practitioners or family doctors, have an important role to support their patients to reduce their risk factors for chronic disease, whether it's counselling for smoking cessation, having discussions with their patients about the risks of alcohol use, unhealthy eating or physical inactivity.

Similarly, these conversations often also happen in the acute care setting. There are some pretty interesting programs that have been launched in hospitals that deal with people who may have some presence of disease but actually to try to get them to quit smoking and do other things. They also play a role around the progression of disease, diet, exercise and smoking, as I mentioned.

There are other sectors. Again, the Auditor General rightly points out that there are collaborations that need to take place between the Ministry of Health, other ministries and other parts of the broader public sector. Examples would be the Ministry of Education with a school food and beverage policy that requires all food and beverages sold in schools to meet certain nutritional standards outlined in the policy, or equally, with the Ministry of Agriculture, Food and Rural Affairs, a Fresh from the Farm program, or through local efforts, to support active transportation. Bike lanes, for example, actually have a role in terms of getting people to be more active in their journey to work on a regular basis. We work in partnership and in collaboration with these other ministries and partners. Our investment in public health, as I say, is an important part of it but isn't the whole story in terms of how we work to prevent chronic disease.

The Auditor General has made 11 recommendations to improve chronic disease prevention in Ontario. I think we'll have an opportunity today at this session to talk about some of those in greater detail, but I just want to highlight a few, and the work that the ministry has done in response.

First, the Auditor General highlights the need to strengthen provincial coordination through a provincial strategy to guide all chronic disease prevention activities. I've talked about how we've got a number of streams of work. I think they're having an impact, but have they been brought together in a way that actually would be understandable as a strategy and looks at all the moving parts?

I think we have a strong foundation of services and programs in place. We have the building blocks to make significant advancements in the prevention of chronic disease. But the point about a strategy and coordination of effort is a good one. I think we really can do more to make sure that we're developing something that is comprehensive and coordinated in provincial approach. We're confident that if we do that, the upstream interventions will actually produce the result of a healthier population.

To support that consistency, one of the things that has happened between the time of the audit and where we are today is that on January 1, 2018, the ministry introduced public health standards focused on improving outcomes, accountability, evaluation and transparency. Again, I would argue that some of these measures are guided by and are entirely consistent with the findings of the Auditor General.

With the modernized standards, the Chronic Disease Prevention and Well-Being Standard requires public health units to develop and implement local programs of public health interventions that address chronic disease risk factors. These local programs must be developed to address specific priorities—one of the areas, like healthy eating, activity, and sedentary behaviour—based on an assessment of local needs. I think, in this area, we have an evidence base, but context also matters in terms of the needs of the population and where the best effort actually needs to be applied.

We're in the middle of conducting a comprehensive review of all of our chronic disease programs, as we are of many of our other programs, I would add. This review is going to identify gaps in programming related to key risk factors for chronic diseases. We're going to make sure—again, consistent with the report—that measurable outcomes are in place, and we want to make sure, of course, that there is efficient use of funds for all programs. Some of the findings of the Auditor General on duplication, we are in entire agreement with. We want to make sure that we're using our money as effectively as possible.

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Finally, the Auditor General noted the need for a broader government approach which considers the impacts of government policy on population health. I would say that it's early days. I don't know whether we're about 115 days into—

The Chair (Ms. Catherine Fife): Ms. Angus, you have two minutes left.

Ms. Helen Angus: I'm just about to finish; thank you. It's early days in terms of how a government-wide approach could be implemented. We certainly are working to improve coordination and collaboration across the government to make sure that other policies actually support population health goals. I can answer questions about that as well.

I would say that we've also got new guidelines for public health units to assist in operationalizing partnerships in collaboration with schools, so the expectation is there on both sides so that public health units don't have to spend the time and effort to develop the relationship and can spend more time on programming. I think that we've done some work to address that.

In conclusion, I would say that we've taken action on many fronts, working with multiple sectors. We agree with the recommendations of the Auditor General. I hope you see that we've made solid progress in acting on those. Moving forward, we know that these recommendations will continue to be a guidepost for us as we continue to work on chronic disease and work with our public health partners.

I'm joined by two esteemed public health practitioners. I know that you'll have all kinds of questions and, given that they've spent their careers on this, I know you'll want to hear from them.

The Chair (Ms. Catherine Fife): Okay. Thank you very much. Since those calorie postings have been made public, I haven't had a Cinnabon since that time, I'm telling you. I guess that's progress.

To the government side: Mr. Miller.

Mr. Norman Miller: Thank you for your opening presentation. The government is spending a lot of money on public health and on fighting chronic disease—$1.2 billion in 2016-17, and $192 million to reduce chronic disease—and yet it seems like we're losing the battle. When you look at the numbers, the prevalence of people living with chronic disease is going the wrong way.

Yet it seems so simple when you read the common-sense things that we need the population at large to adopt

to make a huge difference in the quality of life and the costs of the health system. I think we probably all know them. They're well stated here: We have to get more physical exercise; if you smoke, stop smoking, or reduce smoking; reduce the amount of alcohol you consume; and have healthier diets. That's basically it. It just seems like we're spending a lot of money and there are a bunch of different programs, but we seem to be losing.

Some other provinces have different approaches. I note that in Quebec they have a Health in All Policies approach, and along the same lines, in the 2012 report from Cancer Care Ontario, they recommended a whole-government approach for primary and prevention of chronic disease. I can't help but think you're trying to effect fairly simple behavioural change that the health units are trying to do on their own with programs that they can't even get into all the schools. We'll get to that, I'm sure, in detail later on, but there are some programs in schools.

You have a program for drinking—setting out a moderate drinking guide. I can't think that that's going to make much of a dent in trying to effect behavioural change, so it seems to me that a different approach, like a Health in All Policies or an all-government approach where you're really trying to get kids at a young age to start being active and stay active their whole lives, so obviously you need the schools to be involved with that, and you need communities; you need people to be involved in minor hockey and baseball and to develop things they're going to do their whole lives.

On the drinking side of it, I'm not quite sure. I don't think a guide telling me how much I should drink would necessarily affect how much I do or don't consume. But I guess your comments about whether you think this approach that Quebec is taking with Health in All Policies that was recommended by Cancer Care Ontario—a whole-of-government approach—if that is worth considering.

Ms. Helen Angus: I guess the short answer is yes. I think that behaviour change at a population level is pretty difficult. It's probably hard at times in our own lives, but it's also difficult to achieve that scale of change in how people live their lives.

I think that one of my colleagues here will be able to talk about dose response, but I think you need enough intervention to actually make a change. Some of it is about programs and information, but some of it is about supportive policies: Is it the ads or is it the fact that tobacco is not shown in stores and all of the other things that actually make a difference in the legislation?

I might ask Peter just to talk about how complex—Dr. Donnelly, sorry—it is to get behaviour change. Because it takes policies and legislation and supportive communities and all of the things that you've identified, I think that this all-of-government approach has appeal. We're just kind of working out what that would look like and how we would build it into the existing processes of government, which are kind of complicated, at best.

Mr. Norman Miller: I would assume, then, that you would be considering, if you're trying to get everybody more active, that cycling would be something that would be part of that all-of-government approach, or it would be considered if you were contemplating how you would get people to do cycling-to-school or bike-to-school programs.

Ms. Helen Angus: Yes, making it safe for kids to bike to school, for example. Absolutely.

Mr. Norman Miller: Sorry, go ahead.

Dr. Peter Donnelly: A lot of very thoughtful points; I'm not sure I'll do justice to them all, but I'll deal with as many as I can remember.

I just want to start by cheering us all up. It's not all bad, okay? If you look at life expectancy in Canada over the last 100 years, it has increased by 25 years. So we're all living longer. One of the reasons there's so much chronic disease about is that, if I think back to even when I was a junior hospital doctor working in ER, guys in their fifties were dying of their heart attack; now they're surviving. People are living with chronic disease for a longer period of time.

So it's not all bad. There are a lot of positive things that are related to the fact that we have a burden of chronic disease.

If we look at why the improvement has happened, in the early years, it was about reducing infant mortality, but later on it has much more been about these lifestyle things, particularly reducing smoking. That's another success story, because smoking at the peak was 50%—half of the population smoked—and it's now 17%. It does show that you can make a difference.

Turning to your point about Health in All Policies, if you're good at accents, you'll have worked out that I haven't always lived and worked in Canada; I've only been here four years. The place I worked before was—

Mr. Norman Miller: Is that Scotland, then, I assume?

Dr. Peter Donnelly: Yes, well done.

Mr. Norman Miller: My mother was born in Glasgow.

Dr. Peter Donnelly: Some people assume it's England—anyway, but Scotland.

One of the things they did was look at this in a sort of health-across-all-departments-of-government approach. It's an approach that the World Health Organization recommends, and it's exactly the kind of stuff that you're talking about. It's actually about challenging different parts of government—both centrally and locally—on how they can contribute to this.

Let me finally just say a little bit about the balance between doing things on a provincial basis and doing it locally. I honestly think you need to do a bit of both. There are some things it makes sense to do once. We do a lot of things at Public Health Ontario on behalf of all of our colleagues out in the field. There's no point in them crunching the data 35 times when we can do it once for everyone, for example.

For some of the stuff and some of the things that you alluded to, like local safety initiatives to encourage kids to cycle to school or take more exercise, that actually needs to be driven by municipalities that are very closely aligned with public health units. It probably is a case where you actually need to do a bit of both.

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Finally, I want to make one more point. You said that we're spending a lot on chronic disease prevention, and I think you, if I remember rightly, quoted a figure of somewhere between $1 billion and $1.5 billion.

Mr. Norman Miller: It was $1.2 billion out of public health, and $192 million on chronic disease.

Dr. Peter Donnelly: Okay. What I know you realize is that a big chunk of that $1.2 billion is about keeping us safe—from SARS, Ebola, Zika and other things that threaten society—so it doesn't just deal with chronic disease prevention.

It's also important to put it in the context of the overall health spend in this province, which is more like $50 billion. So if public health seems a lot at $1.2 billion, remember that that's only 2.4% of the total health care spend, and that it includes the very important task of keeping us safe, which is what my agency is predominantly focused on.

Mr. Norman Miller: My feeling is that there's great opportunity in this area to save the whole system a lot of money. I'm not sure how you achieve that. I'm suggesting this cross-government approach, but I do believe that we can save a lot of money.

Of course, our government has made a focus on hallway health care and ending the crowding in hospitals. If we were doing better with some of the chronic diseases, I assume that that would make a difference in the congestion in our hospitals. Do you want to comment on that at all?

Ms. Helen Angus: Yes, I would agree. I think that every smart health strategy would push interventions upstream so that people don't have to come to the hospital in the first place, or use other health care services and increase the overall health of the population. That's very much in the forefront of our thinking as we look at any hallway medicine.

It's not just adding capacity, because I think obviously there is a need to do that, but it actually is trying to look upstream at interventions that not only keep the population well but also, even for those who already have a chronic disease, try to help them manage their care in the community and not in a hospital setting. That may mean being quite innovative about how we intensify home care services and other things.

We're trying to kind of fire on all cylinders, to be fair, to really tackle the phenomenon of hallway medicine, but we need to use all of these different levers in order to be able to make a difference. I have great confidence in Dr. Devlin and his committee because they're going to give us advice in some areas—as well as the advice of my colleagues here on the real prevention area.

Mr. Norman Miller: You were talking about the success in the smoking cessation programs. I guess the obvious thing that has happened in the last couple of weeks is legalization of cannabis, so another form of smoking. I would think that could be problematic in terms of hurting the efforts you've made, so I wonder how you're going to deal with that.

The other part of smoking that I see as a problem in Ontario is the whole contraband tobacco area that really falls outside of whatever good work you're doing. If you're buying cigarettes from a bag wherever, ID is probably not getting checked and the rules really don't apply.

So those two issues, in terms of the smoking part of it, I'm just wondering about.

Ms. Helen Angus: Yes, I would say that there's a perfect alignment between our approach to smoking and to cannabis.

Dr. Williams, do you want to talk about the risk factors—what we know about the harmful effects of cannabis and then also how we're actually making sure that we're using the same—it really doesn't matter what you smoke; it's basically the same rules, pretty much.

Anyway, over to you.

Dr. David Williams: Yes, thank you, Deputy.

Thank you for the question. These are the ongoing challenges that we have as we try to respond and to work with our public to make them aware, as they decide to partake or to not partake, who should and who shouldn't, and how do we put the prevention public health approach to the whole model? We've been working on that for a number of years across Canada.

As you know, the harmful effects of cannabis smoking are the same as tobacco, because you're still inhaling burnt materials. You have the same risk of pulmonary disease, the same risk of asthma and complications therein as well as the risk of addiction. And there are acute things that are related, similar to tobacco, but you have other ones related to concentration, the ability to make decisions. The amount that you're consuming and the effects on the person: They're breathing more heavily—deeper—and holding it longer, so they have, potentially, more effects than cigarette smoking, in that sense, so it's not benign in that way.

Then you have the other forms of cannabis that are, of course, still in this form of evolution, of coming out—the vaping side as well as the edibles side and oils. This is going to be an evolving situation. We're going to try to keep the public educated and look at the right checks and balances with our legislation as well as at the federal level, with the licensing, to ensure that their safety is kept in mind. We mostly want to protect our youth. We know that early consumption has an effect on brain development, even up to the late teens and early 20s, with the males. So we have to keep this going forward.

We had drafted low-use guidelines that were from the chief medical officers of health from across Canada, in conjunction with our agency here in Ontario, CAMH. It's this public education of what you do with this responsibility, and to keep that messaging going. We have that ahead of us to keep working at diligently, much like we've done with tobacco, as Dr. Donnelly has alluded to. That wasn't achieved quickly. We had to keep bringing that forward, as the new information became available on second-hand smoke and other aspects that we've had a tremendous response on.

How will cannabis affect our community? We don't know yet. We have lots of speculation. We have to wait to

see what's going to happen. We're up for the task, but we're going to have to stay at it and keeping working at it.

Mr. Norman Miller: I have lots of questions, but I'm going to pass it over to MPP Surma, who, I know, would like to ask—

The Chair (Ms. Catherine Fife): MPP Surma.

Miss Kinga Surma: Thank you very much, MPP Miller.

We've known that the legalization of cannabis was coming down the pipelines for some time now. Why hasn't a public awareness campaign in terms of the negative effects of cannabis on individuals come out to the public? I haven't really seen any real campaign. Can you explain that?

Dr. David Williams: As we were aware that it was coming forward, there has been actually quite a bit of—not from the government per se. At this time, we had a lot of education from the public health standpoint on that, about people being aware. Our experts in the field—that is, from CAMH and others—have been putting out reports and talking to the medical associations. They've been putting out their reports and their materials. There has been a lot of dialogue along that basis there.

Miss Kinga Surma: That wasn't my question. I understand that there's dialogue between experts, but I want to know why the negative effects of cannabis on an individual were not made public. Every single person I speak to in terms of the negative effects of cannabis—most people are just not aware of all of those things that you mentioned earlier.

We knew this was coming down the pipeline. Cannabis has been legalized, and the public has no information about the negative effects of cannabis. Can you explain why that is the case?

Ms. Helen Angus: I might actually ask Roselle, the former ADM, to come up.

There has certainly been work done, to Dr. Williams's point, on a public education campaign.

The Chair (Ms. Catherine Fife): Okay. So there's someone else who wants to come up?

Ms. Helen Angus: Yes.

The Chair (Ms. Catherine Fife): Okay. Come on up, please.

Ms. Helen Angus: Is that okay?

The Chair (Ms. Catherine Fife): Yes; it's totally fine. She just needs to identify herself for Hansard, please. Then, perhaps, you can answer Ms. Surma's question.

Ms. Helen Angus: I just want to make sure that we give the best answer possible.

There are two streams of work. One is public education, and then it's also, as Dr. Williams suggested, the work with providers and other groups in order to identify the risks so that they can have that conversation—their interaction with the people of Ontario.

Maybe, Roselle, you can talk a little bit more about the two campaigns and how they work.

Ms. Roselle Martino: Sure, absolutely.

Roselle Martino, former assistant deputy minister of the population and public health division.

Before I answer your question, I would like to thank very much the Auditor General for the collaboration on the audit. I really appreciate that, Ms. Lysyk. To your audit team, Sandy and Kim: Thank you very much.

A couple of things. The first thing is that, absolutely, you're right about the public education campaign. What we are doing collaboratively in the ministry and with the rest of the government is working with the federal government, who were launching a broader comprehensive public education campaign across the country, so there was consistency there. That's the public message, if you will.

What we are doing specifically in Ontario is actually complementing or augmenting that public education awareness campaign with specific resources that have gone across to all our health system partners. Primary care physicians do have resources about the harms of cannabis, for themselves as practitioners but also to give to their patients, if asked.

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Public health units also have received the same thing, again, to be able to educate their communities about the harms and the awareness. It's not just the guidelines; it's actual resources. Schools have the same thing, as well as long-term-care homes etc.

The Chair (Ms. Catherine Fife): Sorry to interrupt; you have two minutes left.

Ms. Roselle Martino: We've worked on a comprehensive campaign with resources, but also to complement the federal education campaign and awareness on the harms of cannabis.

Miss Kinga Surma: Which federal education campaign are you speaking of? Can you describe it for me, please?

Ms. Roselle Martino: I don't know the name; I can't name it. The federal government did—gosh, I will come back with the name. But they have launched an actual public education campaign.

Miss Kinga Surma: Does it mention all of those effects that were highlighted by your colleague there?

Ms. Roselle Martino: Yes. There are different components to it but it does mention certain elements of the responsible use of cannabis.

Miss Kinga Surma: "Responsible use"—I'm not sure what that means.

I'm asking you if in that federal campaign it outlines to the public all of those negative effects that your colleague mentioned.

Ms. Roselle Martino: It does outline the effects—well, again, it's "responsible use." It's a legalized substance now, so we have to make sure that what the federal government has done is they've used what is the responsible use of that. I can't recall specifically if it outlines all the negative effects. I'll have to go look at the public education campaign.

Miss Kinga Surma: Does it outline any?

Ms. Roselle Martino: I believe it has some context. Again, I don't want to misspeak. I can certainly get back to the deputy on that.

Ms. Helen Angus: We've also talked about making sure that if that campaign is inadequate, then we will have to do our own, right? That has certainly been part of our conversation—

The Chair (Ms. Catherine Fife): Thank you. We'll come back to that, MPP Surma, okay?

We'll now go to the official opposition. MPP Morrison?

Ms. Suze Morrison: Thank you so much. First up, I want to thank you all for coming today. I have a few questions that I want to start with.

Just for some context, some of my background has been in health equity work, specifically working with Indigenous communities on- and off-reserve.

My first question is actually about the public health chronic disease prevention management that's the subject of this report. Is any of that work currently done on-reserve in First Nations communities or is that piece led federally through Health Canada?

Dr. David Williams: An excellent question. The answer is yes and no. Some of our health units have an agreement under the HPPA to work with it, such as Peterborough, with their two reserves there. They're combining some programming in that level there.

We have some other areas: We're working up in northern Ontario, both with the Sioux Lookout First Nations Health Authority and with WAHA, developing some areas that would be of cross-interest, and what they would like to work on—because it's under their jurisdictional responsibility—and how we can move resources and information material into their scope and field that they could use and utilize. Again, it's a negotiation respecting that it is their decision on how they want to make it culturally appropriate for their setting, and the priorities of what their chiefs, band council and elders would like to implement.

This is a very important issue. Even in our new standards, we have that requirement that we have to have a dialogue and work with Indigenous communities—because we want to—so therefore we have a reason to do so. But that's, of course, going to be on a basis of being available to consult when we're asked to and how we can work alongside them. We can't impose the programs and services but we certainly are most willing and would like to work with that—and to learn more about the cultural perspectives and how they view it, so that any messages and services are appropriate and sensitive to the traditions.

Ms. Suze Morrison: Perfect.

Dr. Peter Donnelly: I wonder if I might, with your permission, just add a couple of sentences to that. As David has explained, it is a sensitive issue about exactly where the jurisdiction is, and you know this very well because of your past experience.

But one of the things that we have been doing at Public Health Ontario, and this really goes to the tone, I suppose, of one of the earlier questions, which talked about doing things once rather than 35 times—I'm paraphrasing. What we've done is we run things called locally driven collaborative projects where we get our local public health partners to tell us what they are most needing help with and what they would most together like to work on. Interestingly, one of the things they came up with in these last 12 months is they wanted help on how best to work with Indigenous people and with First Nations communities. So we have a group of interested public health units working with us at Public Health Ontario to try to help everybody learn how to achieve the sort of things that you're interested in and that Dr. Williams was talking to. It's a good example of blending provincial and local and doing things once rather than doing them 35 times.

Ms. Suze Morrison: Thank you. Are you aware of how many public health units across Ontario have participated in Indigenous cultural competency training to help advise any of that work? I know that training has been offered in the health sector through some of the LHINs, and I'm just wondering if you're aware of the uptake of that training across public health units across Ontario.

Dr. David Williams: We don't have the number offhand; we've asked—and it's required. I know from my health unit, we had already undertaken that before I came down to the ministry. It was all part of the process, and most have undertaken that. Do I have the tally? They've signed off on all of them, because they're autonomous in that way, but I don't have a number in front of me. We could always assess that to see where it is. I'm hopeful it's getting close to 100%, but I can't tell you what the number is.

Ms. Suze Morrison: Okay. Thank you. Yes, I do think it's particularly important, having noted in the report that some of the issues that were raised in the audit were around collaboration with communities and, specifically, getting at that equity piece. It's one of those tangible measurement pieces. If we can measure the cultural competency of the health units, it can drill down into that equity piece.

My next question is related to some of the cross-collaboration and coordination with other services, for example, in the school boards. In the report, we noted that some public health units were only engaging with, I think it was, 28% of the schools in their area, and some were only providing one service to 18% of schools in their region. I know that when we look at this from a social-determinants-of-health perspective, we can see that one of the main drivers of poor health outcomes and poor health is poverty. Particularly, what comes to mind is the Code Red project that was done in Hamilton—I think that project has got to be about 10 years old now at least—where they did a postal code analysis of income next to a number of health outcomes, like child mortality rates and expected lifespan, and saw the direct correlation by postal code of health outcomes versus poverty.

I'm particularly concerned about whether there has been an equity assessment done of which schools the health units are prioritizing and which ones they're actually working with. Is it those high-needs, at-risk, low-income neighbourhood schools that are the ones getting access to that service, or is it that the 72% of schools that aren't being collaborated with by public health units are the ones in the poor neighbourhoods?

Dr. David Williams: Excellent question. It's a discussion I really like to have on that matter.

I think what we're trying to address is that, in the past—way in the past—we had quite a bit of involvement in all the schools and then there were directions in past governments to pull back out of that school involvement except for immunization, dental and a few other programs. Now, since the AG report, with the revised Ontario Public Health Standards that Ms. Martino led the review on the whole aspect there, we have included a school health program that legitimizes and requires back involvement in all the schools. That's one aspect, as well as cross-referencing with the Minister of Education etc.

So this is a reinsertion back into that setting, not prescribing exactly what you need to do but, like you're alluding to, how you would go about that and with which schools and which programs. There are some things required in all, and there are some things that allow some flexibility. I think the one you're getting at is very important, which is that we're allowing them that, under the new Ontario Public Health Standards, around issues of the format for health equity as well. That means it's another requirement that they have to look into and use that in the overall delivery and decision-making.

There is a requirement also to look at your data: How good is that data? Can you tell which of your schools maybe have more need than other schools? They now have the freedom; rather than saying you have to do everything to every school exactly the same way prescriptively, you have the capacity to allocate and put your resources where, with evidence supported with data, you would like to put that. It would all be part of what they call their service plan, which is also being required. This is all new as of January 1, 2018, after a lot of work by the population and public health division, by PHO and by the field to collaboratively come together, make a fairly, I would say, extensive revision of the programs and standards—which was the old title; now they're the Ontario public health standards—including all of these other aspects in there that you've alluded to.

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I think we're on the edge of a challenging yet exciting new direction where we can look at doing that identified priority work in certain areas of need to understand that data, get that data, work with that better and look at more outcomes, as the Auditor General has asked for in the report.

All of the points you made are excellent, and we're looking forward to the delivery of the new standards by our public health units as they roll them out in their first year of activity.

Ms. Helen Angus: I would just maybe add, David, that we're trying to also bake that relationship in between education and health. We talk about, I think, in our response to recommendation number 4, that we actually have a directors' forum established between the Ministry of Health and Long-Term Care and the Ministry of Education to address opportunities and to really try to cement that collaboration.

Again, it's not being brokered one by one by one—obviously, that's part of it in the service-offering—but actually it's to make that that's an expectation. Those relationships are made easier on the ground because of that work.

Ms. Suze Morrison: Thank you. I have one last question before I turn it over to my colleague. Switching gears just a little bit and in follow-up to some of the comments related to cannabis that my colleague across the way was making prior, it's related to cannabis edibles, which we know is a piece that was left out of the recent PC legislation. I'm wondering if you can speak to some of the public health concerns around edible cannabis and any initiatives currently under way to address those concerns.

Dr. David Williams: Yes. As the federal legislation has rolled out on one level with the licensing of some of the materials and agents in there, we're waiting for some further materials from them on the edibles side. We haven't received all of that material yet. As a result, there are various things out there that have various concentrations, various levels of THC and CBD and things like that. We really need that to be, in my mind, much more standardized and identified, so that if someone is going to consume something, do they know what they're getting, what's the quality of that, what's the standardization of that? This still has to all be moved forward on.

So there are concerns on that and other products. Cannabis isn't just an inhalational issue only. These other ones, I think, in this ongoing evolution as you hear from the federal level—and then we have to look at it from our level. All of this is in what we're reviewing and trying to understand, and how do we then incorporate that, as previously asked, with more public education on those components, where the public is asking certainly for the information? If and when it becomes legal and available, how is it going to be sent out, how is it going to be handled? There are many questions to be answered, as well as a lot of education, awareness and knowledge transfer to the sectors, as well as to the public.

Ms. Suze Morrison: Thank you.

The Chair (Ms. Catherine Fife): MPP Gélinas.

M^me^ France Gélinas: I will more or less go through the report as I ask my questions.

The first recommendation from the auditor ends with saying that, in the long term, they would like you to "publicly report on Ontario's overall population health status." I take it, Dr. Williams, that falls within your responsibility. You have put forward some really good reports on public health. I thank you for that. They tend to be specific to one area of public health. The auditor recommended that we have Ontario's overall health status. Is this something that we can expect from your office?

Dr. David Williams: Yes, and I'm glad you brought up the reports. I did bring copies in case you wanted them—en français, also.

But part of that is, when we talk about my reports to the Legislature on the health of Ontarians—there are various ways you can view it. It doesn't say specifically that it has

to be on a report card and overall data. But that's one point we can do, and I can choose those things of interest.

What you will notice in my last two reports, which I have copies of here, is they detail that one of the aspects that we do need is better data, especially around the lifestyle quality side, and enough granularity that we can address it. So if we're talking about Ontarians, we want to have not just the overall picture, but can we give enough detail to our health units and sectors to say what is going on, as the question previously asked, if there's an addition around equity and distribution? Because, as Dr. Donnelly alluded to, we say, for example, smoking is down to 17.9%; we can feel happy with that. Well, we could, and yet there are sectors where it's still at 49%, and so how do we know that? What kind of detail? Because then we have to target our programs as our OPHS gets it, so we'd like to do that.

M^me^ France Gélinas: But that is specifically—as I said, I read your report; you do a very good job. But you talk about data—the auditor recommends that in Ontario we should have overall population health status. I fully understand the importance of the specific report that you put forward, but where can we get this overall population health status report that we could follow over time?

Dr. David Williams: At my office, we've been working at how we can develop that so we have things in place. I can't really say definitively yet because we're still waiting for approvals on that. But I would agree totally. That's what I see as a priority. While I need that for my reports, everyone needs that. So we have, I think, taken from the Auditor General's recommendations that the better we have that available—we have steps in place to achieve that but we have to get approvals for that process. I can't comment—

M^me^ France Gélinas: Who would give you approval to do that?

Dr. David Williams: The government would have to.

M^me^ France Gélinas: Okay. I was there when we hired you as an officer of the Legislative Assembly. You have a responsibility to report to us. Why is it that you need government approval to do something in your role reporting to the Legislative Assembly?

Dr. David Williams: Because the implementation of an enhanced surveillance system on behalf of the province of Ontario will involve expenditure and budget approval on that basis. I can ask, I can recommend, as an officer of the Legislature—quasi-officer of the Legislature. But what it does require, then, is will there be a response in that area and will there be adequate resources and materials to carry it forward? Because any surveillance system does require investments, and investments over time, in order to be a quality system, so we want to make sure we have a quality process.

M^me^ France Gélinas: So the recommendations that you have put forward right now—can you share with us what is the scope of the resources that you need? What would it look like? Is it similar to what we see in British Columbia, or have you got something bigger and better?

Dr. David Williams: Well, I always like to think I have something bigger and better, but that's my aspiration. But, no, I can't comment on it at this time.

M^me^ France Gélinas: No? And are you hopeful that we would see something within the next—by 2019-20? Or is this an aspirational goal, that we'll both be retired and it still won't be there?

Dr. David Williams: I'm hopeful, and the 2019-20—you'd have to put things in place so that, when the data will start to become available, it is comprehensive. I can't imagine it will be next year, but we're going to try and work towards that, to build those systems for the future. Right now I am hopeful but I do not have that formal process approved.

M^me^ France Gélinas: Okay.

Dr. Peter Donnelly: It might be helpful if I just add something. David is quite right that getting new data has a cost to it, but there's also a question about what we do with the data that we do have already. I think we have a good-news story to share there—and this is progress, some of which has been made since the Auditor General's report—which is that if you go to Public Health Ontario's website, you will find a whole lot of stuff there.

We have reports called Snapshots, for example, which will look at data in all of these important health-related behaviours, will break them down by public health unit, by LHIN, by LHIN subunits. What it does is it allows local public health units to actually tailor their response so they can focus on areas of greatest need, because as Dr. Williams has correctly pointed out, it's not the same all over the province. There are some areas that have very distinct problems.

A good recent example, actually, of what we've just put up there is the opioid data. We've got that from all sorts of different places. We've got it from the coroner and we've got it from colleagues who work in Kingston, and we've pulled all of that together and put it up on our website because I think it's really important that, when we're facing a public health crisis and tragedy like that, the one thing that is in all of our interest to have is the truth up there on a public website so we can all see it, and so that we can all tell how we're doing against it.

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M^me^ France Gélinas: I would agree with you, but then another recommendation of the auditor is that—

The Chair (Ms. Catherine Fife): Two minutes, in this question set.

M^me^ France Gélinas: Okay. You collect, manage, analyze and interpret the data, and then it brings us—I know it's a little bit further down in her recommendations. Not every public health unit is able, or has the capacity, to do the interpretation of this data. Data is one thing, and I agree with you that there are a lot of new sets of data that are available. At the individual public health unit, how do we make sure that they have the whereabouts to do the interpretation of those?

Dr. Peter Donnelly: In some cases, because we do it for them. I was describing our Snapshots product—and this is all publicly available on the website. It really does

a lot of the hard work for them. Notwithstanding that, understandably, some of the smaller public health units require additional help in interpreting and utilizing that data, so we do provide that assistance. Some of the bigger public health units—the Torontos and the Peels—have very strong epidemiological and informatics skills, and they don't need that type of help from us, but the smaller ones do.

M^me^ France Gélinas: Do you see a need for bringing equity throughout the public health units, or is this a model where it should all be centralized and be done with the people that are gathering the data? It seems like we have a mismatch out there.

Dr. Peter Donnelly: I think the challenge here is the one that we alluded to before, which is that you really need a balance of provincial and local: provincial, because it is efficient to do things once, but local, because then when you respond to data, you've got to understand the communities that you're serving. You've got to be able to tailor the response to the local needs. So it's not an easy answer. I think you need a bit of provincial and you need a bit of local. But it is something that we'll keep working on.

The Chair (Ms. Catherine Fife): Thank you, Mr. Donnelly.

Now we'll go to the government side: MPP Parsa.

Mr. Michael Parsa: Deputy, Doctor, and Doctor: Thanks very much for coming.

I have a specific question. The four factors that were highlighted and named—you were talking about smoking less, unhealthy eating, better diet, physical activity and drinking less alcohol. We all know the importance of early prevention. What steps have you taken specifically to educate the youth at an early stage? Whether it's through the boards—I know some were referenced. What specific initiatives are you taking to be able to put in those early preventions, and to educate the youth on the importance of these four factors?

Dr. David Williams: It's an excellent question, and we've been at it quite a while in that. The good news is, as some of the parents say, "We thought it was going to be a quiet time around the dinner table, but we're getting a lecture from our grade 4 student on what is healthy and not healthy."

There have been a number of things that have been going out through our education, with our staff giving materials to the teachers, materials on that. We have the school health program that can link over on that. We have our healthy kids challenge that was rolled out in the last number of years, and looking at a number of factors around that.

Educating children and youth on these factors has been, continues to be and will be a very critical component. Their knowledge base of, "When I went to school, we didn't have much on that"—they don't say how long ago that was.

At the same time, the amount of knowledge, when I watch and listen—and the parents coming back with how they're strong about things with smoking; they're strong about concern with drugs; they're concerned about eating and proper nutrition.

We don't emphasize too much with weight, except for physical activity and body image and a positive sense and feeling there. We want to make sure that the right style of messaging is getting through.

Giving materials over for the education of the committee, as the deputy talked about, and looking at those resources—teachers already have a very busy agenda, but at the same time, I find they're very receptive to educational materials that are proper and conducive for their classroom setting.

A number of health units are doing different things in different ways. We have many examples of their taking on very unique challenges. One of the advantages of Ontario, now with 35 health units, is that they sometimes are taking very different approaches with different youth and schools—in programs; out at the community level; with community club activities and awareness on campaigns; and youth taking leadership, having them doing various contests and activities.

So I would say, in large part, our youth are certainly a lot more informed than I was when I was a kid. I think that is important and will continue to be important because they're the adults of the future. They're already making some shifts and changes. We see that happening. I never thought I'd see the day when most kids' school lunches had more salads and snacks in them than some of the junk food we used to have. That just shows you the trend and the change in direction.

Peter, do you want to comment on that at all?

Dr. Peter Donnelly: I would like to just add a comment. I think there are some really interesting lessons to be learned from the change in levels of cigarette smoking. As I said earlier, it's quite remarkable. It has fallen from 50% to 17%. There's a lot we can learn from that.

What were the kinds of things that made the difference? One of the things that made a big difference was to stop advertising, because what became very clear was that big tobacco were deliberately targeting kids. The sorts of ways they were promoting their products were things that were very appealing to children, particularly young teenagers. When they were stopped from directly advertising, of course, what they moved on to, then, was to sponsor events, in a way, which were very appealing to young people. For example, you may remember they used to sponsor motor racing. It got to the point where you wouldn't even need to see the brand name on the car. Simply the flash of colour across the screen would be enough to register in your mind who the sponsor of that vehicle was.

That kind of legislation, which is very much in your hands, as legislators, rather than in ours, as officials, can be very impactful. We've now moved toward plain packaging around the world, for example, again, actually to inhibit the way in which products are placed in front of young people. There are things that can make a big difference. You need to have those sorts of legislative approaches alongside the educational ones.

Mr. Michael Parsa: I'm glad that you brought up the point of advertising, Doctor. Back to the question of my colleague earlier—and you referenced and put the category of marijuana into the same one as smoking. These preventive measures that you put in—and you talked about advertising. I've got a marketing degree, so I understand that quite well. Will you be doing the same thing when it comes to cannabis, for example, in the future, showing the—

Dr. Peter Donnelly: That's clearly not for me, as head of a provincial agency. You'll understand that. That is something which is a policy issue and, indeed, I believe, will be a federal policy issue rather than a provincial one.

Mr. Michael Parsa: Last question: I understand that some segments of the population may be at greater risk of chronic disease. How can we ensure that all segments of the population will benefit from the efforts to prevent chronic disease in Ontario?

Dr. Peter Donnelly: A fabulously important question, on which David and I could probably speak for a couple of hours each, but here's the short version. The short version is, it's got to be driven by the data that I referred to before. That's what my agency seeks to make available.

Number two: It's got to be driven by the understanding of the science so that we know that what works is actually applied. That's what my agency does.

The third thing is, it's got to be tailored to a local community. Honestly, if you try to have one-size-fits-all that comes out from Toronto or Queen's Park, and you send it to other parts of this province, people are going to turn around and they're going to say, "You know what? You don't understand our local community. You don't understand our local youth. You don't understand the challenges that we face." You've got to have that tailoring between people who understand the local population in the public health units and, indeed, the locally elected politicians. Then you've got to have the science and the data made available to them from the centre. That's the combo that we all seek.

Mr. Michael Parsa: Great. Thank you, Doctor.

Dr. David Williams: I think that's a very important question, as was the previous question.

We're asking our health units to look at that issue, because we know that, while some of our higher socioeconomic status groups are doing very well in some of those risk factors—with alcohol, it's not the usual case because some who have a lot of money can spend a lot of money on alcohol. But for the other ones, there's a higher level of risk factors in there. That means, then, that our universal messages are doing one job, but now we have to have some more targeted work. That will be more unique, and each health unit is going to say, "How do we approach this group that has a higher rate of smoking and less physical activity?" Because they don't have fitness club memberships and things like that, so then what's appropriate, and why put things out of reach that they can't get to?

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We talk about the built environment work with our municipal partners to say, "The way you're structuring means this group, which may be low-income, now has no way to get to that place and walk to it to achieve it. How do we assist with all these things there?"

These are very situational assessments and solutions that can come forward, and that, in my reports, I was trying to augment we have to move on. I think that our challenge now is to say that since all of the risk factors are not distributed homogeneously throughout the province, we have to look at our high-risk, because they're the ones who tend to fall into our emergency departments, and have not had the privilege of working with some of those issues before. How do we make sure that we target programs that are appropriate for them, have meaning and can demonstrate some impacts, as the Auditor General has asked us to demonstrate? This is the opportunity ahead of us and the challenge ahead of us.

Ms. Helen Angus: I guess I would only add that, on occasion—I've spent 10 years working at Cancer Care Ontario and I worked on a prevention plan for cancer specifically. Certainly, the thinking was that when smoking rates were up at around 20% at the time, it was the last 10% or 15% that was going to be toughest, right? So your strategies also have to change over time, as you think about—the next 5% might be a little bit easier, but there's always going to be a residual population that's either resistant or extremely hard to reach. I think your strategies have to either increase in their effectiveness or in the dose or in something to get to those very low numbers that we all hope to get to. It is a constant process of looking at the evidence, looking at what's getting traction, and then course-adjusting as required.

The Chair (Ms. Catherine Fife): MPP Ghamari.

Ms. Goldie Ghamari: Thank you so much for today. I want to talk a little bit about the numbers and the overall budget. I noticed that, out of the $1.2 billion spent on public health and health promotion programs, $702 million of that is directed toward public health units. That's roughly 58%.

In reviewing the Auditor General's report, she indicated that, due to the lack of coordination at the provincial level between the Ministry of Health and the Ministry of Education, public health units spend resources to build relationships and persuade schools, which is something that, I guess, should have been done at the provincial level as opposed to at the local level.

My question is, do you know how much has been spent on those efforts? What percentage of the money allocated is going to this, due to the fact that there's no collaboration between the ministries?

Ms. Helen Angus: I'm not sure if I can give you—I don't know if Roselle has a number for how much time was spent brokering relationships that should have been put into place provincially. I would say that part of the new standard and the expectation is that you don't have to talk your way in the door; there's an expectation of that relationship.

As I mentioned earlier, I think that the directors' forum between the Ministry of Health and the Ministry of

Education is really there to identify opportunities and have a collaboration provincially that supports locally—

Ms. Goldie Ghamari: Sorry—that's fine. I just wanted to know if you have a number. What percentage of the money allocated to public health units was spent on resources to build relationships, given that this is something that should have been at the higher level? I'm just looking for a number or a ratio. If you don't have it, that's okay.

Dr. David Williams: We won't have the exact number, just because the school program was introduced on January 1, 2018—

Ms. Goldie Ghamari: Sorry to interrupt; my time is limited. I just want to get through it. I have a lot of questions.

Would it be possible to maybe get that number as a ratio or something? Because I just want to get a better understanding of how much of the money is going towards GS&A. How much of it is going towards administration versus how much of it is actually going towards implementing services? I'm just trying to get a sense of that.

Ms. Helen Angus: That may be an easier question to answer than to say, "How much of the staff time is used in brokering relationships?" So, why don't we see what we can do in terms of breaking down the public health budget and the activities, because we would have certain structures—

Ms. Goldie Ghamari: Great. I would also be interested in the time as well, because that time can then be translated into dollar amounts, right? So, how much of someone's annual salary, for example, is spent on this unnecessary work—in that sense. That's my first question.

My next question sort of follows up on that. Let me just bring it up here—right. In terms of the oversight, in terms of the kinds of programs that are being provided, you got the four key areas. I think they're all important; however, I'm noticing that there is a disparity between the resources being spent on one particular area versus the overall impact or importance.

For example, a lack of physical activity accounts for the largest proportion of health care costs compared to the much lower percentages for diet and alcohol, and yet 86% of the public health units ranked healthy eating either first or second. Given that there should be a greater focus on physical activity, why are resources being spent more on other programs that will not have as much of a usual impact? What's being done about that?

Ms. Helen Angus: Maybe, David, you can add in here. But I think it's important, again, to go back to the point that public health units are part of a larger system of providers and interventions that are aimed at improving people's health.

Some things don't cost any money, like where tobacco can be advertised, where it can be placed and plain packaging. It really—

Ms. Goldie Ghamari: Sorry, I should have clarified. My statement specifically talks about resource allocation. It says 86% of the public health units "ranked healthy eating either first or second ... while only 14% ranked physical activity first or second in terms of resource allocation." This is specifically with the money that's being provided, and the funding.

Ms. Helen Angus: I'll let you answer, but I think part of it is where there are other interventions like in schools that are dealing with physical activity, maybe the health units would put more emphasis on things where their interventions actually make a difference.

Do you want to answer that—probably better than I can?

Dr. David Williams: I'll attempt to answer it. If you're asking about health units, they would rank all the more important. If you ask them to rank, they will try to rank. At that time you're asking about, that survey, the big concern then was around overweight in children. That was a priority at that time, especially with nutrition and eating. Physical activity is not far behind.

Most health units I know would not say that one is important and the other is not. That's the trouble with the survey; you get their opinion. Each health unit can make a decision. It depends on the demographics and what they see to face, and what the responsiveness—what they think can make the best impact at that time, in that way. If you ask them again today, it might be a different list. I think they would like all four of those.

Ms. Goldie Ghamari: Yes. My question, and I guess I should have clarified it—it's not within the context of the school system, it's just the overall resource allocation in that sense.

Another question I have, because you mentioned the 2018 school health guides, so I just quickly looked through that. My understanding is that boards of health need to develop and implement a program of public health information. They're mandated to do an assessment of the local population. Are they going to be provided with any support from the ministry level so that it doesn't really eat into their resources again? Or are they expected to do it all on their own, which would then possibly contribute to duplication of the same work?

Dr. David Williams: Right now it's part of their budget that they take in there. What we've given them in the new Ontario health standards is the capacity to prioritize based on their service plan. So if that seems to be an area they want to focus more on, they can reallocate resources over to that area to work on that, if they choose to do so. How much they do is their prerogative.

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The Chair (Ms. Catherine Fife): There are two minutes left in this question set.

Dr. David Williams: We don't budget them line by line. They actually get a budget that they're asked to put together and send back to the ministry, which we will get back later, to see what they are doing, supported by their annual service plans, which are just coming in. We're looking at those, at the first phase of how they've done that. This is different this time. We can see that some health units will do more on this and others will do more on that—and what's the rationale, what's the data? As it

says in the guideline example, why did they make that decision, what supports that decision?

Ms. Goldie Ghamari: Typically, what percentage of their budget goes towards these sort of assessments or reviews, or whatever the case may be, as opposed to actually providing the services? Has the department looked into the possibility of taking on this responsibility themselves so that, of the resources being provided to them, they're not spending it on this? Let's say the ministry retains one or two experts to develop an overall model for everyone—in the long run, it could potentially be much more cost-effective than having each local health unit have to retain their own experts in that sense.

Dr. Peter Donnelly: I think I'm beginning to get your question now—sorry to be a little slow on the uptake.

A lot of this is what Public Health Ontario does. One of the most time-consuming things for a local public health unit is to assess the evidence around any particular intervention that they might want to provide, and the reason is that there are always more and more papers coming out and some will say something and some will say the other. Pulling them all together and saying, "On the balance of probability, what is the best thing to do?" is actually quite a technical and complicated task that we undertake once for all of the system and then put up on our website. I don't know if that helps. That's something that we try to do once to save everybody time and—

The Chair (Ms. Catherine Fife): Thank you. Maybe you'll circle back to that in the next question set.

MPP Gélinas.

M^me^ France Gélinas: I'm still on auditor recommendation number 1, but I hope to progress a little bit faster this time.

Your answer starts with, "The Premier's Council on Improving Healthcare and Ending Hallway Medicine will provide advice on the provincial approach to promoting health and preventing chronic disease." If I turn that on its head, as in, what do you see health units, through their mandate to prevent chronic disease—how can they help end hallway medicine? I can think of a hundred ways. But I would like you to tell me: What is the role of health units in ending hallway medicine?

Dr. David Williams: It's an excellent question. We could have a hundred ways to do it. That's one of the advantages there.

When we are talking about chronic disease—which the deputy already alluded to, what per cent that does partake, and what Dr. Donnelly mentioned—if you take in line that chronic disease itself is not a stagnant issue of the last 10 to 15 or 20 years; it's moving and shifting. As Dr. Donnelly alluded to, part of the reason that our numbers are up—it's a good-news thing, in one aspect, because people were dying sooner. The success of our health care system, including our physicians and the hospitals and that, under the concepts of primary, secondary and tertiary prevention, is that people aren't only living longer with chronic diseases—so ones who were dying in their fifties and sixties are now 80 and 90. But that means the prevalence, the numbers go up. That means there's a challenge to the system. They're not just in beds. They're actually quite active, with three or four chronic diseases, which is a good-news story. It's a challenge at the same time.

Part of our hallway push is to say, how can one be healthy with chronic disease? You can make good decisions with the risk factors or bad decisions. You may have, as we alluded to, a predisposition to diabetes. By making choices earlier, you can limit that and the impacts on you, including the long-range consequences of that that would make you end up in a hospital bed and be one of those hospital-bed patients.

M^me^ France Gélinas: What's the health unit's role in that?

Dr. David Williams: I think the health unit's role in that, as we continue to push on the promotion, is to say, in your communities, if that kind of information is not throughout and is not reaching your most vulnerable group—because we know that a certain per cent of the population is one of the biggest consumers of the health care costs and of the hallway ALC beds etc. They tend to, at the eleventh hour, fall into the system. How do we reach those high-risk groups sooner with programs and services? Because many of them are marginalized and disenfranchised from connections and things that they need to access sooner, either because of unawareness or they're unable to—various reasons. How do we work at that better so that they're linked in: empower them, in their own way, to get what they need at that time—because with what could have been helped earlier just with an intervention, now they end up in the emergency department and in the hallway?

M^me^ France Gélinas: Isn't that the role of primary care, not public health?

Dr. David Williams: The answer is yes—both. As we work with primary care all the time, they're doing that at the same time. But some of those patients are not even accessing primary care.

M^me^ France Gélinas: You don't see a public health strategy specifically coming out to end hallway medicine?

Dr. Peter Donnelly: I wonder if I can give a very specific example around cigarette smoking. What's important to understand is what problems people have when they're stuck in the hallway of a hospital. They have chronic diseases. Very specifically, they have things like heart attacks, stroke and cancer. Here's the good news about giving up smoking: If you smoke and you give up, within one year, you've halved your risk. You have half of the risk of somebody who continues smoking, of having a heart attack. Within five years, you've got half of the risk of having a stroke of somebody who continues smoking—

M^me^ France Gélinas: But health units are not in hospitals.

Dr. Peter Donnelly: —and within 10 years, you've halved the risk of cancer. Why does that make a contribution? It makes a contribution because, if you can actually stop people from having the events that take them into hospital, it actually reduces the pressure on hospitals.

Public health units have an important role to play in driving smoking levels down through the provision of smoking cessation services. Dr. Williams is quite right that that is done in conjunction with primary care physicians and primary care nurses.

M^me^ France Gélinas: Okay. Can we expect, then, the smoking cessations that have started to continue, and can we expect the modernization report that we got on tobacco to be used and put into place? Or am I too far off?

Dr. Peter Donnelly: No. I think you're along the right lines. I think the work that's being done in providing modernized public health standards is very important. I think the fact that we have data done on a provincial level but we allow people to show local discretion so they can tackle the most pressing things for them locally and tackle the parts of their public health units that are most in need is important.

So no, I think you can expect public health units to continue to bear down on the things that cause hallway medicine, which are things like smoking and alcohol and obesity and lack of exercise.

M^me^ France Gélinas: If we stick with smoking for a sec, we saw in the US, with the Food and Drug Administration, they have a levy on the industry to pay for their strategy. Ontario had, just this spring, put out their report for the new strategy. Can we see something like this coming forward?

Ms. Helen Angus: I think it's really the government's prerogative. I know it's still early days, but it seems consistent with a multifaceted approach to ending hallway medicine and making the best use of the capacity. As I say, it's not just a capacity issue; it's a human issue about making sure that people are able to live long and well. That's clearly fundamental to the work of the ministry. What the minister and the government decide to do—I think I'll let them speak for themselves on that.

M^me^ France Gélinas: Fair enough.

I got from what you've told me that the modernization report on tobacco is still something that guides, and that you see public health units, through chronic disease prevention, have a role to play in ending hallway medicine. Am I putting words in your mouth or is that true?

Dr. Peter Donnelly: No, that's clearly true. Look, anything that bears down on the major causes of chronic disease is going to make a contribution to reducing the pressure on ERs and therefore to reducing hallway medicine.

M^me^ France Gélinas: Okay.

Go ahead, Dr. Williams.

1400

Dr. David Williams: To add to that: In the new standards, one of the requirements is that there is a relationship now of reporting from public health, the medical officer of health, to the local health integration network. That input from the community side, that might have an impact on policy decisions in health services, is available now. That wasn't in the old ones. That's a new venue, to see how that works.

So, in a way, yes, there is a connection. In the past, we would be doing our job on the outside. We can now connect across and say, "Here's the data and information," and they can also have discussions back and forth.

There's an attempt to have a better dialogue—with the challenge, of course, of how you end hallway medicine.

M^me^ France Gélinas: All right. I'm now on recommendation number 2, which is looking at Health in All Policies.

My understanding of Health in All Policies is that you look at the impact of a government policy on health. So, if you take building new developments, you would like those new developments to have sidewalks so that people walk. This is Health in All Policies. If you're going to give permissions for a developer to build 100 new houses, he or she will have to put in a sidewalk so that people can walk.

We just had the policy on cannabis. It was supposed to be 50 stores; it's now in the thousands. We all know that accessibility to cannabis is one of the parts that will drive the use. How can you reconcile Health in All Policies and the fact that the government made the decision to go to 100 stores rather than 50? Were you ever consulted on the health impact of that decision?

Ms. Helen Angus: I certainly wasn't consulted. We may have had an opportunity previously, with the previous government.

I think Health in All Policies is probably a work in progress. Certainly, we're looking at how that might actually be implemented and those health considerations be brought to bear.

I would say policy-making, obviously, is a prerogative of the government. It's also multifactorial in terms of, you know, what is health? Prosperity is health; other things are health. I think we need to be mindful of that. I think that's the complexity of implementing this. Income is health, and—

M^me^ France Gélinas: How about you, Dr. Williams? Were you consulted?

Dr. David Williams: Not on the changes recently. But I would say that Health in All Policies—there can be the formal process and the informal. Certainly, in my experience over the last number of years—because one of my tasks is, I go around to different ministries—there's much interest in health impacts.

When I present, sometimes to a council of deputy ministers, health wasn't—they didn't have to ask the question; they knew what I was going to say. The rest asked a pile of questions. They're all very interested. They put health, quite often, informally, so while we don't have a formal one—the Ministry of Transportation, OMAFRA, MECP and different ones, they all have health aspects they like to refer to in there. I found not only an openness, but they want to have a dialogue, or I may go and talk and talk. They say, "We've got five things we want to discuss on health impacts."

I find that the informal interest in putting that in their policies and referring to it—it's something they want to consider, even if they don't have a formal one. It's an

aspect that, first, my office would continue to promote in my role of going around to different ministries.

M^me^ France Gélinas: Dr. Donnelly, were you consulted?

Dr. Peter Donnelly: No, we were not consulted on the particular model for retailing cannabis, but I'm not sure, frankly, I would necessarily expect to be consulted on that. It's a very complicated issue with, I suspect, many interweaving policy aims, including, no doubt, the suppression of the black market in cannabis. It's a very, very complicated issue—health is certainly one of the factors—but it's not something that my agency would have any particular expertise in, the retail model of cannabis. I think there would be others who are probably better placed to lead on that.

M^me^ France Gélinas: Back to Dr. Williams: Some health units were pretty vocal about vaping. When you gave the example—I think it was to Mr. Miller—as to how to curb tobacco, one of the big successes was to curb advertising. Now we have a bill that allows advertising of vaping. I take it you all know Juul; I don't have to tell you what that is. What do you figure will be the health impact of Juul being able to advertise their vaping products in every Shell gas station and, soon, every Esso gas station?

Dr. David Williams: I think that's an excellent question. Since these were only licensed in this past year—the materials and that—we've been after Health Canada to look at some aspects around there. At the federal-provincial-territorial committee level, we're very concerned about the marketing of one of the companies, in particular, which you noted, with their line of products that very much seem to be youth-orientated. There are questions being asked and discussion on there.

All along, if there is marketing in these new areas there, we are looking strongly at how to limit that and what we can do with that, especially if it's targeted to youth in that aspect there. It's new and it's coming out, but it doesn't mean that we're not vigilant in doing that, in bringing the issues to the table, and we'll continue to address those on a very much assertive level, if there's any aspect that's going to be prioritizing our youth market. We're concerned already and we want to keep working on that.

M^me^ France Gélinas: So let's say—

Dr. Peter Donnelly: Can I just add to the vaping answer, if I may?

M^me^ France Gélinas: Yes.

Dr. Peter Donnelly: Because it's a very interesting and complicated issue, vaping of tobacco. It's one that, frankly, has somewhat divided the public health community.

On the plus side for vaping, if you are smoking combustible tobacco and you've tried other ways to give up and you really, really can't give up, vaping is not safe but almost certainly safer than conventional smoking. As such, vaping may make a contribution to reducing the cancers that otherwise flow from smoking combustible tobacco.

On the other hand, nobody can say that vaping is entirely safe, because we don't have enough accumulated data. It hasn't been in existence long enough. Perhaps more relevant to your question, if vaping becomes a way for a whole new generation of young people to become addicted to nicotine, then I think that is something that would concern all of us. Because once somebody is addicted to nicotine, they obviously can feed that addiction in various ways; one of those ways is to continue vaping, but another way would be to turn to combustible tobacco.

I think that's a reason why a balanced, cautious approach is appropriate here, in particular, to look long and hard—as I think Dr. David Williams has indicated—at whether the way that vaping is marketed is particularly appealing to young people. Because if that is the case, I really don't think that's helpful.

M^me^ France Gélinas: So the position that some of the health units had put forward when the bill was being debated, that they wanted advertising of vaping to be the same as the advertising of tobacco: You don't advertise; you go into a specialty shop if you want to stop smoking and they will show you. You're basically saying that that had merit?

Dr. Peter Donnelly: I'm not aware of the positions that any one of the 35—soon to be 34—public health units took on that particular issue, but I would understand the point they were making. If they were expressing concern that advertising may particularly target young people, then I would understand the concern.

I'm sure, in taking forward any legislation, this is going to be a matter of active debate. But it will be for the government and the legislative process to deal with this issue, so I defer to my colleagues on the right, if there's anything else that they wanted to say in this regard.

Dr. David Williams: We're active on it, especially at the federal level.

M^me^ France Gélinas: The question was based on the Auditor General's second recommendation, to look at Health in All Policies, an integrated approach to setting policy. So what I've heard you say is that it's not going to be the model that we saw in Quebec, but when you have an opportunity to speak up, you take it. Am I correct?

Ms. Helen Angus: That's probably where we are now. We haven't had a discussion with the government yet about how we might implement this recommendation. I think I'd like to have that before I make a commitment here.

1410

M^me^ France Gélinas: Okay. When you answered—and I realize that it may not have been you; it might have been Bob Bell who said, "The ministry has initiated work to evaluate the pros and cons of adopting an approach that requires policy-making to evaluate" the health impacts. It goes on to say that you expect it to be "completed in mid-2019." Apparently, you're supposed to have that done by next June. Are you going to meet your target?

Ms. Helen Angus: Again, I have great faith in the work of the ministry. Again, it's a government decision about how they would want to implement this.

The Chair (Ms. Catherine Fife): Two minutes left in this cycle.

Ms. Helen Angus: We're certainly looking at options about how that might be, then, embedded into government decision-making processes.

M^me^ France Gélinas: Okay. I'm moving on to recommendation number 3: "to better address the risk factors that contribute to chronic diseases." In your findings, you say, "In support of this recommendation, the ministry is doing a comprehensive program review of all its chronic disease prevention programs." Could you share the list of what you will be reviewing, and who is in charge of that? When can we expect this to be done?

Ms. Helen Angus: We're looking at a lot of our programs. I would say that we're taking the recommendations, for example, since this report of the Ernst and Young work that was done on behalf of the government that would have a line-by-line review of all programs. That work is being undertaken across the portfolio of programs within the Ministry of Health and Long-Term Care. This is specific to the work that is happening on chronic disease, but we want to look at everything in terms of: Are they achieving outcomes? Are they effective? Are they efficient? To the questions earlier: Is there duplication that we could eliminate in order to push more of the work into the interventions that are going to make a difference?

Those are the kinds of things that we're looking at. You may want to enumerate the programs; my job is not to leave any stone unturned but to actually look at those programs. Again, the value-for-money audits that the Auditor General has done in the health care sector give us a running start related to the line-by-line review that we're undertaking. We've got some general themes. We have a lot of programs at the Ministry of Health and Long-Term Care.

M^me^ France Gélinas: Yes, but focusing on the chronic disease prevention program, who would be leading this line-by-line? I thought the line-by-line was done, that we paid this guy, he came and did the line-by-line. Aren't you guys doing something different?

Ms. Helen Angus: They gave us some general parameters, and they did good work. But I think there's actually work that we need to do as a ministry looking at programs.

The Chair (Ms. Catherine Fife): Thank you, Ms. Angus.

In this next cycle, the opposition has 14 minutes and the government side has 14 minutes. We're going to return to Ms. Ghamari.

Ms. Goldie Ghamari: Just to follow up on your most recent comment, I think that there's no need to look and see whether there's any duplication or not, because the Auditor General's report is very clear that there's a lot of duplication.

The work that you're doing is so critical. We're talking about people's lives. I understand that, as medical professionals, you're doing an excellent job. But I think the way that it's structured is just not working. With respect to your answer, for example, in the sense that, "We're going to give local public health units the option to do it themselves"—well, it's not working, because, based on the report, we're finding that they're either not able to meet the needs or they're not assessing anything properly. Just looking at the mandate of Public Health Ontario, it seems like the mandate of PHO is to do the assessment and is to do all of that hard, technical stuff—take all the data, make it into a nice bundle and then give it to the local health units so that they can then focus the administration of services based on local needs. In order to understand what those local needs are, they need to have the data from Public Health Ontario.

That's one of my concerns, because even when I look at this developing of a program of public health intervention—the most recent one, in April—there's a figure there, figure 5, which is developing a program of public health. I'm reading that, and it's very difficult to follow along. It's just using these big buzzwords like "upstream approach" and "proportionate universalism."

If we're talking about, let's say, a public board of health—for example, in Ottawa, I'm looking at the board, and it's made up of six city council representatives, two medical professionals and two people who work in different—one works for the Ottawa Mission and one works for Ottawa Community Housing. How could you expect a board like that, for example, to properly develop these sorts of technical guidelines? To get to my question, have you actually even considered looking at the fact of just doing it all yourself as part of your mandate, in order to provide these public health units with the data that they need so they can get their job done?

Dr. Peter Donnelly: I think it's a great question and let me not duck it at all. Let's just go to the heart of your question, okay?

Public Health Ontario was established 10 years ago in the wake of SARS, so it was established to respond to a very scary outbreak of communicable disease. People never wanted to be in the position again of not being able to do a good job, and so what they did was they began to pool the resources relevant to that.

Let me tell you what we have at Public Health Ontario. We have 950 staff, but more than 600 of them are front-line lab workers who do the tests for HIV, tuberculosis, hepatitis, and actually over 300 separate disease entities. In many cases, we're the only people in the whole province who do those tests, and we do them for front-line clinicians, whether they're in ER, hospital intensive care, or whether they're working as family doctors.

We then have a group of people who do the sort of work that you're interested in, which is they look at data and they look at evidence and they try to produce it and put it out there to the field. But unfortunately, when there was the transfer of resource into Public Health Ontario, it coincided with the financial crash of 2008. So the resource that was going to come across to do health promotion and chronic disease prevention—it was never possible for the ministry to take that across.

What we've done is we've gradually moved—

Ms. Goldie Ghamari: Sorry, just to—

Dr. Peter Donnelly: We've gradually moved money across to address this, but currently, what we're able to do is to spend about $4 million a year, if you look at the

figures in the pack, of our $175 million a year on health promotion and chronic disease prevention. Now if what you're saying is—

Ms. Goldie Ghamari: Sorry—I completely understand everything. Sorry to interrupt, because our time is limited.

Having said that, has Public Health Ontario ever looked at, or will you now then be looking at, what the cost would be to do all of these assessments? For example, with respect to the auditor's recommendation and the assessments that you are now saying that the public health units should do, even though it's very technical, and a lot of these key indicators—I don't think they're qualified to provide Public Health Ontario with that sort of information.

What is the cost-benefit analysis of Public Health Ontario doing this for all the public health units versus the public health units doing it themselves? Why couldn't that cost just be taken out of whatever is given to public health units in this overall $1.2-billion budget? I mean, let's assume that it costs the public health units, I don't know, $10 million to do it collectively, but it would cost PHO $5 million to do it for everyone. Why could that just not be a transfer of $5 million here and there?

Dr. Peter Donnelly: Okay, I understand. That's very clear. I understand the point you're making.

Look, we already do a great deal for our local public health units. More importantly, we do a lot in collaboration with them. I think it is very important to make the point that there's very considerable expertise in public health in the public health units and we need to make the most of that.

But if you are challenging us to say, could we collectively look at this and find an even more efficient, collegiate way to do it, we'd be up for that challenge.

Ms. Goldie Ghamari: Do you ever communicate with the public health units in that regard and get their feedback on whether or not they're capable of doing this stuff? Because my understanding from reading the report is that not only do the public health units not have the same level of resources, but they've indicated that a more coordinated approach provided by, let's say, Public Health Ontario would make it more efficient and cost-effective.

1420

Dr. Peter Donnelly: Actually, some of the public health units are extremely well funded. They are considerably bigger than we are, for example.

Ms. Goldie Ghamari: And some are not, as well.

Dr. Peter Donnelly: And some are not; I take that point. But we do have regular dialogue with them about how we can be most helpful. I referred earlier on to what are called our locally driven collaborative projects, where they say, "Here are the things we're struggling with. Here is the help we need. How can we, together, do this?"

If your challenge to me, as the head of the public health agency for this province, is to say, "If I was given a free hand to modernize Public Health Ontario—if I was given a chance to respond to some of the challenges in the EY report to take things forward and reshape the way we spend our money," I'm absolutely up for that. What I need is a free hand to be able to take that forward, but I'm absolutely up for that challenge. My agency could do that.

Ms. Goldie Ghamari: Was that ever, let's say, communicated with the minister at any point in time? During the time you've been at Public Health Ontario, has that ever been brought up? Have you ever communicated that to the ministry or indicated that perhaps there are ways that we could modernize this because it's just not working?

Dr. Peter Donnelly: Let me tell you what has happened, because this is a matter of public record and it's something which I think we can build on constructively: My agency has been flatlined for five years—no increase. We have a unionized workforce with binding arbitration. That means we have year-on-year increases—you understand that—on top of which, of course, we do around six million laboratory tests for front-line clinicians. We have no control over that. We can't say, "We've done all the tests we're going to do"; we just have to keep doing the tests. So we have cost drivers that we have to deal with.

What we went through was a very collegiate, thoughtful and constructive process with our colleagues in the ministry that said, "What could we envisage doing that might reshape the balance of services provided by PHO, reshape the way we spend our money and reshape the way we provide our service?" But we then got to the point where the election was imminent, and that, in a way, just froze everything, as you will understand.

What I think will now happen going forward is that (1) out of financial necessity, because of the flatlining I've referred to, but (2) because, frankly, there's a lot in the EY report that I read, accept, agree with, and I would like to act on—so what I'm looking for is actually the opportunity to change, reshape, modernize and produce a public service that we can continue to be damn proud of, because PHO is a very special institution.

Ms. Goldie Ghamari: I have no doubt about that.

Dr. Peter Donnelly: The only thing that comes close to it in North America is the CDC in Atlanta. We want to keep keeping this province safe. Working with David and Helen, I have every confidence that we can do that.

Ms. Goldie Ghamari: You have been doing a fantastic job, so thank you so much. I really appreciate that.

The Chair (Ms. Catherine Fife): We are going to move to MPP Wai. I just want to let you know, though, that you have three minutes left. If you want to share, you need to be succinct.

Mrs. Daisy Wai: In fact, I have a few questions, but I will just focus on the two that I have in here.

Before I say that, I just want to reiterate that education is so important. We see the importance of the effective way we have done with cigarette smoking. Please reflect this through—we need to do marketing, advertising and education in the schools. I would like that to be re-emphasized.

The two questions that I have here are, first, could you please tell us a bit more about some of the legislative levers the government uses to address chronic disease prevention?

Ms. Helen Angus: Yes. We talked a little bit about that in terms of the Smoke-Free Ontario Act, for example—David, maybe you want to go on about this because you've got more depth of understanding—but plain packaging, where products can be displayed; you can't smoke in public places, in cars or beside playgrounds. Those are all things that are included in legislation that give us the levers to change behaviour. So it's not programming, but it actually bakes in some of those rules into what people can do in Ontario.

I don't know if you want to add much to that.

Dr. David Williams: No, that's an example, and that's on the smoking side, with lots of things around enforcement of sales to minors and different activities there, and there's a licensing withdrawal capacity if that's found to be a case. There are many checks and balances in place there.

With alcohol, there are things around safe-server legislation that requires the activities in there. We try to do things on the alcohol side as well.

Cannabis: We're going to have to keep working on that one now that it's in and has been introduced, and how we're going to facilitate that.

Aspects we're trying to work on in a collegial way, with the menu labelling act that came out: That seems to be well embraced, both by the industry and, as Deputy Angus alluded to already and as the Chair alluded to, how it's impacting them when they're reading the safe menu act on that aspect there.

So there are a number of legislative things in place that we are trying to work on for those four risk factors to bring that to attention and to certainly limit those areas of most concern, especially around access to youth and blocking that in very many venues, as well as future discussions around locations and places like that. That dialogue continues.

Mrs. Daisy Wai: Perhaps I'll put—

The Chair (Ms. Catherine Fife): Thank you, Mr. Williams.

I'm sorry, Ms. Wai, that's 14 minutes. We'll have to talk about order of speaking, perhaps, next time, so that everybody gets their opportunity. We can also talk about questions that you may have for the committee in our report writing as well.

Fourteen minutes to the official opposition.

M^me^ France Gélinas: You're stressing me now.

All right. I will jump to recommendation number 6, in which you answer that the Sioux Lookout First Nation Health Authority and the Weeneebayko Area Health Authority are currently designing and implementing a data surveillance system to support public health units. I'm just wondering: Who is working on this? Is it still ongoing? Whatever you find out of this to identify data, is this something that would be rolled out province-wide, or am I dreaming in Technicolor?

Dr. David Williams: Maybe Roselle Martino can answer some of that.

With the issue with Sioux Lookout First Nation Health Authority, working with their wellness model, we have been able to work at getting an associate medical officer of health assigned over to the Sioux Lookout First Nation Health Authority who is assisting them in the data collection.

In consultation with SLFNHA and with community members, they're trying to collect the data that they want to collect on the issues that they prioritized to look at. WAHA has a different data collection process, too, because we're not saying they have to be the same.

This is our way of trying to move alongside with resources that would allow the various communities to take the initiatives they want to do to collect the data they want that's culturally sensitive, to use that data in the protection of their ownership, and then how they would assess the values in that and what they would want to carry out on the base there.

We're trying to continually make it sensitive data that's under their control and under their volition and what they would like to prioritize on that basis, with the existing structures there, and move alongside them with those resources when we can, in affiliation with now the Inuit services aspect of the federal government, trying to look at these tripartite, tri-functionalities there, to move alongside.

M^me^ France Gélinas: How far along are we with those two projects?

Dr. David Williams: I'm more up to date on the SLFNHA one as compared to the WAHA one. They have carried out their community consultations and they are collecting more of the data on a couple of priorities they've seen there. I don't have a report as of the last six months, so we'd have to get back to you with that, if we can get that information to you.

Roselle, do you have any updates on that further?

Ms. Roselle Martino: Sure.

The Chair (Ms. Catherine Fife): Welcome, Ms. Martino.

Ms. Roselle Martino: Thank you very much. As Dr. Williams and the deputy were saying, the Indigenous indicators are self-determined. The Sioux Lookout piece of work is a bit further ahead, only because they're a bit more coordinated in terms of getting the community support, and, Madame Gélinas, you know the communities have to give support for their data. Weeneebayko is in the process of going through that same support of their council leadership etc. in terms of identifying what indicators and who they would be willing to share that with.

1430

M^me^ France Gélinas: Okay. Are you familiar with what the Sudbury health unit has done with the Indigenous population, and this is similar to what's being done in Sioux Lookout and Weeneebayko?

Ms. Roselle Martino: I am very familiar. Dr. Penny Sutcliffe actually shared this information with us and it is very aligned, Madame Gélinas.

M^me^ France Gélinas: So is the end goal that we would take the learnings from those two and then replicate them to all of the other First Nations throughout Ontario?

Ms. Roselle Martino: As you know, every First Nations community is very, very different, and so the intention is to look at what are the common elements, with the learnings from those respective two communities, and

see what we can apply across the province, completely respecting the individuality and cultural individuality of each First Nations community.

M^me^ France Gélinas: Are other health units doing the same thing that the Sudbury health unit has done?

Ms. Roselle Martino: Other health units—they're all in different stages. Madame Gélinas, I think you know that in the requirements of the standards there's a new element in there that we actually have a specific guideline to support dialogue and relationships with First Nations communities. I would say that every health unit is in a different space. They are working toward it, but Sudbury is very ahead.

M^me^ France Gélinas: Ah, good to know.

Dr. David Williams: And also, Peterborough has members on their board and they've been working with their two, Curve Lake and Hiawatha, for quite a while in developing the programs there, and Eastern is working with Akwesasne. Some health authorities, like Six Nations, are very much independent and working on their own with their own indicators and things, but we're willing, as Ms. Martino said, with the guidelines that the health units need, to engage and find out where those health authorities in different band councils are at and what do they want, when do they want it and how do they want it. That's part of the ongoing dialogue.

M^me^ France Gélinas: All right. Just as an aside, we now talk about 35 health units rather than 36. Which is the one that no longer exists?

Dr. David Williams: It was an agreed amalgamation with Oxford and Elgin.

M^me^ France Gélinas: Okay. And soon to be 34. Which is the next one that's about to amalgamate?

Dr. David Williams: That's being entertained right now by the two organizations. It hasn't been officially announced yet at this time.

M^me^ France Gélinas: Good enough. You could be a politician.

Laughter.

M^me^ France Gélinas: I am on recommendation number 7, where, basically, "effectively evaluate their chronic disease prevention programs," and the auditor makes a series of recommendations. In your answer, you say, "the ministry intends to explore opportunities for developing and establishing provincial benchmarks in 2019-20." What does "intends to explore" mean?

Ms. Helen Angus: It means we're working on it. We've done the work on evaluation—that's probably the first column—and so I think now we have to look at what the benchmarks might be for the various programs and outcomes. I think the comparability of data, so that we can actually compare what interventions are working, is really important, so the benchmarks will help us do that.

M^me^ France Gélinas: Are there benchmarks that are promising right now?

Dr. David Williams: Benchmarks? I mean, they're always promising to mean more on our protection side but the ones we're looking for on this one here, and especially because this is the first year with the implementation of the new standards, including their assessment, their service plans etc.—we're looking forward to how that work will unfold. There are some indicators being worked on right now, in consultation—they have not been formally approved yet—in a couple of phases, so that discussion is happening right now.

I would say it's promising, in there, and I think it's work that needs to be done and fortunately it is being undertaken at this time.

M^me^ France Gélinas: In what has already been done, you mentioned "in April 2018 to build chronic disease prevention evaluation expertise within the public health sector, as part of the Health and Well-Being Grant Program launched in fall 2017."

Who got those grants and what are they doing with them?

Ms. Helen Angus: They nicely provided me with a list—I wouldn't have had this off the top of my head—but there are some pretty interesting ones here. We can provide the list to the committee if it's better than me reading it out loud.

M^me^ France Gélinas: Sure.

Ms. Helen Angus: It went to the University of Waterloo, Dalla Lana School of Public Health, Barrie Area Native Advisory Circle, the Association of Ontario Health Centres, Ontario Public Health Association—there are a number of folks there who were recipients and are doing work now. We'll see what the results are and we'll evaluate those.

M^me^ France Gélinas: Okay. How many minutes? I want to use my time wisely.

The Chair (Ms. Catherine Fife): You have five and a half minutes left.

M^me^ France Gélinas: Okay. I'm on recommendation number 9: You want to "put in place relevant indicators that are linked to the planned new Ontario public health standards and that measure areas attributable to the public health units," knowing full well that, in a lot of the work that you do, government policy has a big impact on the sorts of outcomes that you can get. In the answer you say "in consultation with stakeholders, and expects to release an updated version by the end of December 2018." Are we still going to meet that deadline? And who is working on that?

Dr. David Williams: Maybe Roselle could answer on that, because it's the project they're working on. There has been work undertaken at this time. While we are on the deadlines towards that, I'll let Ms. Martino answer.

The Chair (Ms. Catherine Fife): Ms. Martino?

Ms. Roselle Martino: Thank you. The work was very well under way, Madame Gélinas, in terms of who's working on it. In my former capacity, we got that to, I would say, a penultimate stage.

Just to clarify, the public health requirements had never been outcome oriented before. The new standards that were released, as the deputy said, in January 2018 are all outcome oriented, and there are two streams that we have identified. There are indicators that actually look at program outcomes: Are the programs that the public health units are delivering meeting the program outcomes that are

identified? We actually have a suite of indicators that match that and can measure that. There's also a set of indicators that look at the contribution to population health outcomes. That's a longer-term thing, because, as the deputy said, many sectors contribute to population health outcomes, but we are capturing the contribution of public health units to that population health outcome.

That work is still under way. In terms of a release, I think that will be up to the minister and the government in terms of timing.

M^me^ France Gélinas: Okay. So the work has been done, it would be ready, and now it's going through approbation, whenever somebody within the ministry has time to do that?

Ms. Roselle Martino: I believe it would have to go through a formal approval process. As the deputy said, we would have to talk to our minister about them and it would be part of the process.

M^me^ France Gélinas: Okay. Deputy, are you confident that those are going to move in time to be there by the end of this year?

Ms. Helen Angus: Well, I'm not going to commit on behalf of my minister, but I would say that we will certainly—again, this audit has sharpened our focus, in the early days of the government, on the contributions of public health to the health status of the population. I think this is an important piece of work, so I will be looking out for that and helping to shepherd it to the minister.

M^me^ France Gélinas: Okay. I'm on recommendation number 11, funding inequities. In your answer, you say—maybe I don't understand English good enough, but it goes "anticipates completing this work in 2019-20, consistent with the enterprise review of all transfer payment recipients." What is an enterprise review?

Ms. Helen Angus: I think that's just the ministry review of transfer payments. I would say that we are looking at the assets that we have in the health care system: Do we have the right number? Are they doing the right job? Obviously, those earlier questions need to be answered. I think there has been some good work done on funding equity, but if we make any changes, the funding model will have to adapt to that. When you kind of see the merger of public health units, what does that mean for the funding? We've had lots of experience with funding models, as you probably know, whether it's in the hospital sector and others. They do take a while to calibrate and be fully implemented. I know in the early days of hospital funding reform, for example—

The Chair (Ms. Catherine Fife): Last minute, please.

Ms. Helen Angus: —we put some corridors on it so that we weren't actually taking money away too quickly from those who had it. So it's a process of rebalancing the funding, again, consistent with the goals and expectations that we have of the public health system.

M^me^ France Gélinas: So nothing to do with this? In my area, the smoking rate is at 28%. Now that cannabis is legal, there is a very high consumption of cannabis with the people I represent. So if predictions are right, we will be at 50% of the people of Nickel Belt who will be smokers by the time everybody who smokes cannabis comes out. Would you declare a public health emergency?

Dr. David Williams: We're all wondering how that will go with the current use. Some other places in the US that have made it legalized found that the percentage overall didn't increase that much. It's "wait and see." We'll have to monitor it very carefully and decide what action we need to take in that regard.

The Chair (Ms. Catherine Fife): Thank you.

I'd like to thank the panel for coming in. Thanks to Ms. Angus, Ms. Martino—for stepping up—Dr. Williams and Dr. Donnelly for your time today.

This committee will adjourn to a private session, and I'll ask members of the public to please clear the room.

The committee continued in closed session at 1441.

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